

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, December 12, 2002
9:44 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: Setting the context for Medicare spending
-- Anne Mutti, Ann Marshall

MR. HACKBARTH: Good morning. At this month's hearing we go into the various update recommendations on the various sectors of the Medicare program to be included in our March report so most, although not all, of the discussion over the next two days will have to do with update recommendations. We will have some other presentations like the first one we have this morning establishing context and then also a few policy related conversations as well.

The final votes on update recommendations will not occur until January so anybody who's here in anticipation of watching that exciting event is going to be disappointed. What that introduction, Anne.

MS. MUTTI: At tab B you will find a draft of the chapter entitled Setting the Context for Medicare Spending. This draft draws together some of the data and information that we have presented over the last few months and adds a couple of new pieces. The purpose of this chapter is to provide policymakers a context for assessing Medicare spending patterns and implications for changes. It is also part of MedPAC's assessment of whether payment met policy supports the goal of the program which we have previously defined as ensuring that beneficiaries have access to medically necessary quality care without imposing undue financial burdens on beneficiaries and taxpayers.

In this presentation I will go over the outline of the chapter and summarize the main points. The chapter begins with a discussion of Medicare spending trends both in terms of the level and of growth. It then compares Medicare spending to overall health spending trends and those of other payers. Thirdly, to help policymakers assess the implications of Medicare spending growth, the chapter addresses various resource constraints that may affect policy choices concerning Medicare spending. And finally, given these trends and constraints the chapter discusses how MedPAC acknowledges and assesses the implications of its recommendations.

In terms of spending trends, we that after an anomalous few years aggregate Medicare spending has resumed its more typical growth rate of about 8 percent over the last two years and this is about 5.5 percent real growth. It is projected by CBO to grow at an annual rate of 6.8 percent over the 2003 to 2012 period or about 4.2 percent real growth.

Among the fastest-growing service sectors over the last two years were home health and SNF, although a number of other sectors were also growing at double-digit rates

including hospice, ASCs, and outpatient hospital services. Medicare spending is concentrated both in terms of service sector and by the number of beneficiaries served. Inpatient and physician services alone account for 56 percent of Medicare spending and as a result even though their growth rates over the last couple of years have been lower than some of other sectors they are major drivers of overall growth.

But perhaps more most noteworthy is the concentration of Medicare spending on a subset of beneficiaries. About 5 percent of beneficiaries account for 50 percent of Medicare dollars and many of these same people are in the top 5 percent from one year to the next. In contrast the least costly 50 percent of beneficiaries account for only about 2 percent of Medicare spending.

National health spending trends and those of other payers is the next section of the draft chapter. While these comparisons are intended to allow assessment of whether Medicare is a prudent purchaser they must be viewed with caution given differences in covered benefits and population. In addition the comparison is compromised by the fact that private insurance spending also includes supplemental insurance spending for beneficiaries.

Nevertheless, we looked at three types of comparisons. First we looked at Medicare spending to compared to spending on personal health care services. This includes spending by other payers and out-of-pocket by individuals on health services and this doesn't include research spending or public health spending, other things like that. We find that until just recently Medicare was a growing share of that spending. It peaked at about 21 percent in 1997 and was 19 percent in 2000.

Second we looked at Medicare spending compared to private insurance spending. And over the long run it appears that the growth rates are similar. And if we take out drug spending for the private side the average growth rates are even closer.

Third, we looked at Medicare spending compared with premiums or spending growth other government purchasers including CalPERS, FEHBP, and Medicaid and found that depending on the time period examined the rates can look similar or quite different. Some of the variation may reflect market dynamics unique to one payer in the time that we examined. But over the last 10 years or so the average rates of growth were relatively comparable.

In this comparative section we also discussed the factors driving the growth of both Medicare and private health spending. We noted that many of the same underlying factors are growing driving growth, including inflation, volume intensity mostly given by technology, and population.

However because the benefit packages cover populations and payment methods differ some dynamics affect one sector differently than the other. For example prescription drug costs have been a big driver for private health spending but not so for Medicare since we don't cover most outpatient prescription drugs.

Similarly demographic changes will influence the two sectors differently. Coupled with increases in life expectancy the timing of the baby boom generation can be expected to influence Medicare spending more dramatically than private health spending.

The next section of the chapter discusses resource constraints that affect Medicare spending or may influence policy decisions. The resource constraints discussed in this chapter are the federal budget, Medicare trust funds, growth in GDP, and the beneficiaries' ability to afford their care. Our findings include that Medicare is an increasingly large portion of the federal budget, the Medicare hospital insurance trust fund is estimated to be insolvent as early as 2018 under trustees high assumptions and 2030 under their intermediate assumptions. According to CBO, Medicare as a percent of GDP is expected to grow from 2.2 percent in 2000 to 5.4 percent in 2030, more than doubling in the time frame. When Medicare, Medicaid and Social Security are looked at as a whole they're expected to account for about 15 percent of GDP in 2030.

Between 1993 and 1999 beneficiary out-of-pocket spending for health care has increased somewhat faster than their growth in income and this trend is likely continue particularly if drug spending growth continues unabated.

In this slide and in the next I want to give you some more detailed information on the resource constraints of beneficiaries, this is sort of one of the new parts of the paper at the moment, and a sense of their health spending patterns. Most elderly, 58 percent in 2000. have income below \$20,000 and are spending an average of 25 percent of their income on health care. When looking at fee-for-service beneficiaries living in the community, Medicare's portion of total health spending has declined between '93 and '99 from 63 percent to 57 percent. This is probably coinciding with their out-of-pocket on prescription drugs growing, because when you look at all beneficiaries, including those who were institutionalized, the proportion has remained roughly constant over the time period at about 49 percent.

The biggest driver behind growth in out-of-pocket spending is spending on non-covered services such as prescription drugs. 57 Percent of the change between '93 and '99 was due to increased spending on non-covered services and 31 percent of the growth was due to increased

costs associated with supplemental premiums.

This chart provides you with a sense of the distribution and composition of out-of-pocket spending. In this chapter we identified four components of out-of-pocket spending: the Part B premium, cost sharing for covered services, supplemental premiums, and non-covered services. As you can see from this chart, those who have the highest out-of-pocket spending, those in the top quartile, spent nearly 50 percent of their total out-of-pocket spending on non-covered services. Again there is concentration in spending but not to the degree we saw with Medicare spending earlier. 5 Percent of all beneficiaries account for 20 percent of total out-of-pocket spending. Beneficiaries in the top quartile spent an average of about \$5000 out-of-pocket while those in the bottom quartile spent less than \$500.

Those who have high out-of-pocket spending tend to be older, use many services, have relatively high incomes, and are more likely to have supplemental coverage, primarily Medigap. Those with low out-of-pocket spending generally fit into one of two profiles. The first group includes relatively young and healthy beneficiaries as well as disabled beneficiaries with stable conditions who use few services. They may have either have Medicare only or additional coverage but they do not pay those premiums.

The second group includes people with comprehensive supplemental coverage including beneficiaries eligible for Medicaid and relatively high income people comprehensive employer-sponsored coverage.

This chapter concludes that given these spending trends and various resource constraints, MedPAC's recommendations should be made and considered with an understanding of implications on program spending, beneficiaries, and providers. MedPAC will highlight these implications in the text of forthcoming reports and will include spending ranges for its recommendations.

That concludes the summary. I'd welcome your comments. Certainly there were some areas that we've been continuing to work on since the draft was sent to you but we welcome any suggestions you might have. And then also, I hope you will get another draft to look at in this form but before the next meeting you will have one in galley form. That's to encourage you to give me your comments sooner than later.

MS. ROSENBLATT: I think this report did a very good job of incorporating the comments we made at the last meeting and the only issue I had with it that was -- there's a comment in there about 2001 being a peak of spending for the commercial market and I don't think that -- I'd be real careful making that statement. I just don't

think that statement is accurate.

Two minor questions, on table 1-1, where it has Medicare spending by category like hospital, inpatient, physicians, and managed care shows up with an average rate for the '93 to '97 period as 29.5 percent, that I think is occurring because of the growth of managed care. And so I think this table would be better done on a per beneficiary basis as opposed to just raw increase in spending because it's kind of misleading.

And then on table 1-2, there are two identical time periods in the table-- there's probably just a typo in the table -- that have different percentages. So there's something where the years don't agree with the percentages.

MS. MUTTI: It was supposed to be '92 and 2002. I'll look. I don't see it right off.

MS. ROSENBLATT: Okay. That was it.

DR. NELSON: I also think this was very well done. I guess the only thing that I didn't see in it that I would like to is some reference to the fact that consumer expectations are probably changing, certainly from what they were when the program was first started. That there's more emphasis on health promotion and disease prevention, that the Medicare population is assigning a higher value to retaining their health, and they don't have the expectation getting old means you get sick necessarily, and that the value that they assign makes it difficult to restrict spending because it's a powerful force that I believe increases demand and will continue to do, so the expectations and attitudes towards personal help that are different from what they were a decade or two ago.

MS. ROSENBLATT: Alan's comment earlier about what we were talking about led me to think, there should be some leading indicators about 2003. A lot of large employers have their January first renewals already. And so if we could put something, in my guess is there are surveys out there. You get into early 2002 but there's no mention of 2003 at all. If we could do that, that would be great.

DR. NEWHOUSE I would actually like to suggest some more work for you. We repeat the, number, which is very widespread, that 5 or 6 percent of the people account for half the dollars. And there's nothing wrong with that number, but people go on to draw some inferences from it. Like if we can only figure out who those people were in advance, or if we can identify them in real time we can maybe prevent things, we can case managed things. I think there's some mileage to be had there but my point about the number is that it's an arbitrary number that depends on using a twelve-month period. It would be a much higher number if we looked at the percent of people that accounted for spending in a month. It would be a lower number if we

looked over a multiyear period. 5 percent of the people would account for less of the spending over a multiyear period than they do in the annual period because you don't have a heart attack every year, mostly.

There's a further wrinkle, which is probably too much work for you, which is to account for lifetime spending. But if you could give some sense, the only numbers I've really seen on this are from Canada, they don't apply here. But you get some sense of how the number changed if you just accounted for even a two or a three year period, I think that would be helpful. The annual numbers kind of get repeated and repeated and then people forget that this is kind of an artifact of how we're accounting for it.

MS. MUTTI: Joe, is your point that you want to get at the persistence? Are they the same 5 percent?

DR. NEWHOUSE: They're not the same 5 percent. We know that. If we look at total spending for a group of beneficiaries, you take the decedents out if you want that's a problem in how you account for the decedents. But that's a problem even with the annual data. Or leave them in as you want. And the decedents do matter here.

But look over a three-year period and say what percentage of people, what do the top 5 percent account for? It's going to be a number that, my guess, is substantially than 50.

DR. ROWE: On this topic, I think there are a couple different ways to slice this. I do, by the way, think that predictive modeling techniques can identify people at risk. And there is of course a population, the population that Alice is most interested in as an actuary, which is the 25 percent of people that account for 1 percent of the expenditures at the other end of the spectrum.

MS. ROSENBLATT: Jack, I can't let that just lie. You know, I thought you were going to go the other way.

DR. ROWE: On the side of the spectrum that Joe was thinking about, I would not agree entirely. I think there is a small subset of the population that are high expenditures during any given period of time, that the proportion will vary depending on what the epoch is, whether it's a day, an hour, a month, a year, a decade. But those are people with events. They have myocardial infarctions, hip fractures, major cancer operations, strokes, et cetera.

There's another subset that I think is even more interesting and might be more amenable to management for prediction, and that's the chronic disease group, which is the subset after that 5 percent, that may be 15 or 20 percent depending on how you count it once you get up into the Medicare age group that account for a very substantial proportion of the resources that are spent. So it's not just the 5 percent that have the catastrophic thing and it's

hard to predict and they only have it once because they either die or they only have it once.

But it's that second group and they are rather identifiable because they utilize resources over time, frequent hospitalizations, multiple prescriptions, many diagnoses, frequent outpatient visits, procedures, et cetera. You might think about that, stratifying along those lines.

MS. RAPHAEL: You make the statement in one of your slides here that over the last two years home health and SNF were among the fastest growing service. In your table you show from '98 to 2002 actually home care rate of growth is -6.3 percent so I don't think that's accurate, at least as I understand it.

MS. MUTTI: We've seen done the data breaking it into different time periods and the data I used in the presentation was just looking at the last two years, the one you're looking at. What we're planning to do for the chapter would be to break it into multiple things, so you'd see the dip and then you'd also see the increase, so that we'd give the whole picture.

MS. RAPHAEL: I remember something from the text something that I was very interested in which is that Medicaid is growing at a faster rate than Medicare. I was wondering if we know anything at all about what the impact of a growing number of dually eligibles has on Medicare expenditures?

MS. MUTTI: I would guess that it makes it more expensive but I'll go back on that and get that for you.

MS. RAPHAEL: I don't whether we should conclude it makes it more expensive, I just would be interested in knowing that.

MR. FEEZOR: Ann, like Alice I thought you did a good job of trying to get a lot of the comments that we made the last time. There was still one that I urged. Throughout there's single line observations, 26 percent of beneficiaries with annual income say between \$10,000 and \$19,000 spend 22 percent, and it's sort of compared to what? Now that one you said there's more to come so I assume there would be. And for instance we talk about the in distribution of the high-risk cases and so forth, probably not dissimilar from the under-65 population. So I would again just urge, as you go back and read through it, to look and I think where it in fact parallels an under-65 it might be helpful to note that. Where it is significantly different then it may offer some other observations.

MS. BURKE: I just wanted to go back to Jack's comments for just a moment, in terms of the small percentage of individuals who use a large amount of the resources. I double-checked the text to see if I remembered this

correctly. There have historically been observations made that a great deal of this spending occurs within essentially the last six months of life. I mean, essentially it's for people who ultimately are, in fact, decedent.

I think in looking at what we know about this population, some understanding of how much of it is in fact, as Jack suggests, the single episode, how much of it is in fact the chronic users who are high end users, how much of it is in fact sort of end of life care, to sort of a further analysis of that but particularly that time frame issue which I don't recall Jack mentioning and I don't recall it being in the text. But at least historically it's been something that people often cite. So I think some further understanding of what that population looks like.

And to the extent that it is different or similar to the under-65s. I mean again, to Alan's point, that some sense of how this differs in terms of a pattern from the under-65s and the private set, I think would be helpful. Obviously the of the number of decedents perhaps alter but not necessarily the episodes. It's an interesting question.

DR. ROWE: I'd like to comment on that. That's very interesting and I'm glad you brought that up, Sheila, because that has been a topic that I think, Congress, in many policy discussions, has had great magnetism for that issue. But I think there are some risks getting into that that we should if you get into that area. Since Ro Sitofsky, I remember at Stanford years ago, first came up with this idea of what proportion of resources is spent in the last year of life and the last six months of life.

Some people then, in government, said we've got to get rid of the last year of life. It's like they discovered that most of the fatalities in train accidents were in the last car of the train and so we should get rid of the last car of the train and it doesn't quite work that way.

I think that the issue is that the proportion of Medicare resources, as I understand it, that's spent in the last year of life really hasn't changed very much in a long time. It's rather stable and it's in the 20s or so percent.

My own view is that the amount of money that's being spent on the last year of life is not inappropriate, it's just being spent on the wrong things. We treat people at the end of life wrong. Our system is designed to give them proper treatments for care at the end of life. So they're in the hospital, they're getting aggressive advanced diagnostic treatments that are painful and costly and uncomfortable and they don't need them et cetera et cetera.

But I do think we want to avoid casting anything about this money is wasted because these people are going to die anyway. I think we want to make sure we don't fall into that trap.

MS. BURKE: Essentially what I want to try to do is avoid exactly the point that Jack has made, which is policymakers have glommed onto this sort of easily explained statistic and suggested that there are behavioral issues involved there, in terms of the payment system. And I think further looking at who in fact this population is and disabusing them of the fact it is suddenly all these people who are going to die within six months which is just not the case for Medicare's history. It has been relatively stable. So I think to Jack's point, a further understanding of that will help avoid some of that kind of let's end the last year earlier.

DR. REISCHAUER: I'm tempted to get into this because of course there's another group that we don't talk about that are very expensive, and those are the ones that if we didn't dump a lot of money on them it would have been the last year of life. And if we didn't, we could average them with the ones that it was the last year of life and bring down the costs of the total group.

DR. ROWE: Another response that I once made, I think when I was giving testimony but I regret I made was well, Congressman what year of life would you expect the most expense to be? The middle year of life? I mean of course it's the last year of life.

DR. REISCHAUER: Ann's plural, I thought you did a really good job on this chapter and I just have a couple of nits on page 16 where we're talking about Medicare in the context of the economy. One is when you mention the 2.9 percent payroll tax you might refer to the fact that it's half paid by employers, half paid by employees in a nominal sense at least. But I was concerned about some of the language where you said Medicare growth is deficit financed more capital would be invested in government debt and less would be available for private investment as opposed to absorbed by government debt.

And then later on you say if Medicare spending is financed by either raising taxes or increased beneficiary contributions there's less capital available for private investment. I think what you really mean is there's less disposal income which is available for either consumption or saving.

Besides that I thought it was a really good job.

MR. MULLER: Going back to Joe's initial point about the data, and I also feel this chapter is well done.

Given the increased visibility or the kind of glomming on, to use somebody else's, phrase of looking at disease management and case management as a way of saving substantial monies in the program, and also Jack's exchange in there between some of the acute episodes that people have, the MIs, versus people with chronic diseases. My

sense is that people with a chronic disease -- for example the people in end stage kidney disease -- they also have a lot of acute episodes. So it's not as if you have this kind of just undifferentiated stay in hospitals when you have chronic disease and other people have MIs and hip fractures and so forth. What in fact happens when you have chronic disease is you're prone to having these acute episodes.

So I would like to see if it's possible at all, as we look at some of these populations that have a lot of hospitalizations and so, forth, are there certain kind of diagnoses, are there certain kind of DRGs they fall into more than others? Because if in fact one of the theses that a lot of people, both at the Medicaid and Medicare, level, are looking at now in terms of controlling cost growth -- and I'm sure this is true on the private side as well because I've heard Alice and Jack speak to their efforts at disease management -- what does that population -- if they're using a lot of resources that we're trying to manage -- what kind of resources are they really using?

And if in fact, as a patient with chronic disease, they therefore have a lot of acute episodes over the course of 10, 20 years of their life, that's different than if they're subject to falls therefore and they may have multiple falls in that 20 year period. They could have repeat heart attacks and so forth. That's different than just kind of having undifferentiated admissions to the hospital.

So if this is a series of acute episodes over a period of 10 or 20 years that would be interesting data to know, especially -- my sense is that it's much harder to do case manager than anybody thinks it is. That somehow just magically we're going to figure out how to treat these populations, as if people haven't thought about case management for 20 or 30 years. So I have some interesting in deciding just how much can really be done by better management of this, and perhaps looking at that, if you could.

How many acute episodes are there in the average chronic patient's years on Medicare, I think that would be helpful to look at that. Thank you.

MS. MUTTI: Just one comment, the 5 percent is from a CBO testimony on disease management, fairly recently that did follow patients over two years at least, so there was some persistence and survival in that. And we need to look at it further and all your points are well taken, but there are a lot in there. I think 47 percent had three or more chronic illnesses. You need to read it in more detail to see exactly what they were but it was the whole testimony on disease management and whether or not that can really cut costs.

MR. MULLER: The hypothesis if you can keep people out of expensive institutional settings; e.g., hospitals or nursing homes, one will save more money for Medicare, Medicaid, Aetna, Wellpoint or somebody and then ultimately the employees and the employer. If in fact you really can't keep them out of hospitals because there are a series of acute things, then you have a different kind of conclusion as a result of the kind of interventions that you could make.

DR. WOLTER: I think another important area that might be noted is the tremendous variation regionally and provider to provider in how some of these services are provided and I think that's a very important topic. If indeed a huge percentage of resources are provided to a smaller number of beneficiaries and then, within that universe, there's tremendous variation from one part of the country or one institution to another there is something there that could be mined that would be helpful. And that may not be our job per say but noting it as we look at these trends might be useful.

MR. HACKBARTH: Thank you, very much. Good job.